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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 04/05/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Cervical epidural steroid injection (ESI) at C6-C7

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR
OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.
Cervical ESI at C6-C7 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with, M.D. dated 09/28/09, 11/02/09, 12/07/09, and 02/15/10
Cervical x-rays and a CT scan interpreted by, M.D. dated 10/22/09
Letters of non-authorization, according to the Official Disability Guidelines (ODG),
from xxxx dated 11/10/09 and 11/20/09
A letter of appeal from Dr. dated 11/12/09
Letters of non-authorization, according to the ODG, from Forte dated 03/01/10
and 03/15/10
Undated preauthorization request sheets from Dr.
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 09/28/09, Dr. recommended x-rays and a CT scan of the cervical spine. X-rays and a CT scan of the cervical spine interpreted by Dr. on 10/22/09 showed a

healed C4-C5 and C5-C6 ACDF with a 2 mm. disc protrusion at C3-C4 and a 2 mm. foraminal protrusion at C6-C7. On 11/10/09 and 11/20/09, Forte wrote letters of non-authorization for an EMG/NCV study. On 11/02/09, Dr. recommended an EMG of the upper extremities. On 11/12/09, Dr. wrote a letter of appeal for the EMG. On 12/07/09, Dr. prescribed Darvocet-N, Relafen, and Parafon Forte. On 02/15/10, Dr. recommended a cervical epidural steroid injection (ESI). On 03/01/10 and 03/15/10, xxxx wrote letters of denial for a cervical ESI.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This patient has non-specific pain and she has no physical findings consistent with radiculopathy or other neurological deficits. The pain description is not consistent with radiculopathy, but is consistent with axial pain. The objective imaging does not demonstrate any nerve root compression. The documentation is not consistent with the ODG criteria/recommendations for an ESI, based upon the facts mentioned above. In the absence of neurological deficits or radicular pain, ESIs are neither reasonable nor necessary. Therefore, the requested cervical ESI at C6-C7 is not reasonable or necessary and the previous adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
The Spine, Simone and Rothman